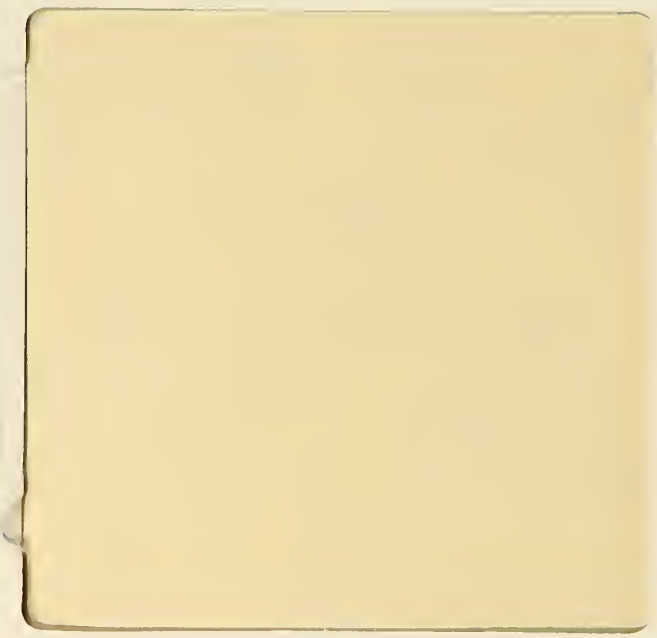
STATE MEDICAID INPATIENT HOSPITAL REIMBURSEMENT

SUMMARY OF STATE PROGRAMS

Working Paper No. 3.3

July 1985

Abt Associates Inc., Cambridge, Massachusetts



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PREFACE

In 1983, the Office of Research and Demonstrations of the Health Care Financing Administration funded a cluster of projects to evaluate changes in the Medicaid program since the Omnibus Budget Reconciliation Act (OBRA) of 1981. The Medicaid Program Evaluation focuses on the increased inflexibility accorded states under OBRA in designing the implementing standards for Medicaid eligibility, reimbursement and service coverage.

As part of this study, Abt Associates Inc. is evaluating changes in Medicaid inpatient hospital reimbursement involving a national overview of state programs and detailed case studies in California, New Jersey, Pennsylvania, Texas and Illinois. The research focuses on four issues:

- What changes have states initiated in response to OBRA?
- What are the broad impacts of these changes on program cost, quality of care and recipient access?
- Are current state programs models for the future?
- What factors need to be taken into account in assisting states to make changes in hospital reimbursement?

The following report is a summary and analysis of each state's inpatient hospital reimbursement program as of October 1, 1984. Each state summmary includes a synopsis of the methodology employed and identifies specific features of the reimbursement system. In addition, this report describes trends in the design and evolution of Medicaid hospital reimbursement nationwide. The report will be verified and updated to reflect subsequent changes in state hospital reimbursement systems.

EXECUTIVE SUMMARY

Medicaid programs nationwide have initiated profound changes in the design of inpatient hospital reimbursement programs since the Omnibus Budget Reconciliation Act (OBRA) of 1981. Prior to OBRA, states used Medicare's cost principles. Granting states increased flexibility and greater authority in the operation and administration of Title XIX programs, OBRA set in motion a variety of innovative alternatives to Medicare's principles of reimbursement. Changes in Medicare reimbursement with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and subsequent adoption of the Medicare Prospective Payment System (PPS), provided a further impetus for change. These changes, including the methods, incentives and control features of Medicaid programs in effect as of October 1984 are reviewed in the following report. Attachment A contains specific summaries of each state system.

As of October 1, 1984, all but nine states had adopted alternatives to traditional cost reimbursement and of these nine states, five are considering changes. External standards such as market basket inflation factors and peer group standards are used increasingly to limit reimbursement, and are being applied to retrospective as well as prospective payment approaches. Retrospective reimbursement systems, those with a final reconciliation to cost but often including other limits, are still used in 15 states. Prospective payment programs, which do not reconcile to cost, are quickly replacing reconciled programs and are found in 32 states, including states which use DRGs to establish reimbursement. (Some states have more than one system in effect.) Contracting and negotiation are also prospective approaches used in several states.

Although for the majority of prospective systems rates are set on a per diem basis, there is a trend toward per case approaches in programs established most recently. Similarly, states are implementing more sophisticated programs which include adjustments and incentive mechanisms for casemix, volumes and special needs of Medicaid recipients. Capital and capacity expansion, mediated through program appeals, are also receiving careful scrutiny in the evaluation of cost containment outcomes.

State Medicaid Inpatient Hospital Reimbursement

Summary of State Programs

This report describes Medicaid inpatient hospital reimbursement programs in the 48 contiguous states, focusing on changes in reimbursement policy since the Omnibus Budget Reconciliation Act (OBRA) of 1981. Prior to OBRA, Medicare's "reasonable cost" principles were the required form of hospital payment for state Medicaid programs. OBRA, however, enabled states to impose more stringent controls over hospital reimbursement than previously allowed under Medicare's reasonable cost methods. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) caused many states with reimbursement systems linked by statute or regulation to Medicare's to move from pure cost-based methods to alternatives imposing various limits and ceilings on reimbursement. Finally, Medicare's adoption of the Prospective Payment System (PPS) heightened state interest in alternative forms of reimbursement and, since it was no longer possible to piggyback on the Medicare system, forced many Medicaid programs to alter their reimbursement practices. Responding to these Federal changes, in combination with growing state frustration at the rate of Medicaid cost increases, Medicaid programs have implemented a diverse range of reimbursement methods tailored more to the specific operational and policy goals of each state.

Thirty-seven state Medicaid programs now use alternatives to traditional Medicare cost reimbursement. The methods, incentives and control mechanisms used by these programs vary considerably, reflecting the differing policy objectives, programmatic concerns and political environments in each state. States overall have shifted from strict cost reimbursement to systems which employ a wide range of internal incentives and external standards. These include retrospective cost-based variations with trend factor or peer group limits; and prospective payment programs which use similar trending and peer grouping categories to project reimbursement rates. Other prospective programs use negotiation, contracting or flat rate methods as a basis for

hospital reimbursement. Of the nine state programs currently retaining cost reimbursement systems, five programs are planning or considering changes.

Individual program features can be expected to affect incentives and disincentives for controlling hospital costs, quality of care and access. Although the efficacy of reimbursement methods, incentive features and control mechanisms across settings remains unclear, states have continued to implement and refine their reimbursement programs along a variety of dimensions. Some of the most important trends are highlighted below:

- State programs are moving from retrospective to prospective reimbursement methods.
- Reimbursement methods increasingly depend upon externally derived standards, such as trend factors, peer groupings and diagnostic categories to establish hospital rates.
- Programs recently implemented tend toward a more stringent selection of base unit and payment incentives.
- State programs are becoming more sophisticated with the inclusion of adjustments and incentives for casemix, volumes and special needs.
- The stringency of program appeals varies greatly across states and is viewed as a serious consideration with respect to program cost containment potential. Control of capital and capacity increases is viewed as especially critical to overall program cost effectiveness.

The following section presents a "snapshot" overview of state programs in effect as of October 1984. Medicaid program descriptions were compiled from secondary and government sources, and have been updated and verified, where necessary, through telephone contact with officials and staff in each state. Individual program synopses are included in this report as Attachment A.

Regional perceptions and differences in terminology used to describe program characteristics and reimbursement methods, the frequency of program changes, and differences between "official" and "nonofficial" program versions imposed some constraints on consistent and uniform reporting of Medicaid reimbursement programs

across states. Anecdotal information supplied by state representatives, however, helped to explain apparent inconsistencies in program design and effectiveness.

Staff availability, Medicaid program size and authority within state government, and data management capabilities were often cited as reasons for selecting particular reimbursement design features, and for the subsequent effectiveness of reimbursement programs across states. The nature of the hospital industry, and perceptions about Medicaid recipient access to providers were also identified as influencing program design and effectiveness.

These factors are particularly important in assessing the structure of state reimbursement systems with respect to overall program stringency and incentives. It appears, for example, that in many states political and legal factors outside the formal structure of the reimbursement system exhibit considerable influence. In some cases, this manifests itself in specific overt system features such as the generosity of the trending factor or stringency of the peer group ceiling; in other cases it becomes apparent through arbitration or adjudication of appeals, adjustments and other reconciliations. The extent to which capital and capacity increases are allowed and incorporated in the system can also significantly affect the cost containment potential of programs which would otherwise appear to be stringent. In short, even though it is possible to analyze programs in terms of the appropriateness of their incentive structure or other structural features, no one element of a reimbursement system determines the system's stringency. Program stringency is determined, ultimately, by interaction of all aspects of the reimbursement system, including those not ammenable to easy observation or classification.

Overview of State Programs

Many states have explored, and have implemented, a variety of reimbursement approaches prior to their current program. As Medicaid programs share information and gain from their own experiences with incentives, control features and

program operations, these methods are further detailed and refined. The reimbursement methods and systems features which characterize current programs are described below.

Reimbursement Method

Perhaps the most fundamental change in Medicaid hospital reimbursement programs across states has been the overall shift from retrospective cost reimbursement to prospective payment systems. While the terms "retrospective" and "prospective" have become well integrated into the language of reimbursement systems design, these terms are not always used or applied consistently in describing reimbursement methods across states. This confusion became apparent in assessing the incentives and intent of state programs. In some states officials and staff described their reimbursement programs as "prospective," apparently to indicate that rates had been targeted prior to the established rate year. Many of these programs, however, included end-of-year settlements and reconciliations to cost, indicating that rates were, in fact, determined retrospectively.

In order to provide consistent classifications related more to specific design features and intent, we have defined retrospective and prospective methods according to whether programs include reconciliation to cost. Prospective payment programs, currently in effect in 32 states, establish reimbursement in advance of the period to which it is applied and do not include reconciliations to cost.* Prospective ratesetting tends to be less sensitive than cost-based systems to hospital-specific differences which may be related to institutional performance and cost. Retrospective systems, including traditional Medicare reimbursement, base hospital payment on costs incurred, and include final reconciliation to cost. Some cost-based variations further limit reimbursement by per diem or per admission/discharge screens. Retrospective methods,

*These systems may include some adjustments after the rate year, e.g., corrections of inflation projections, but do not make adjustments on actual incurred costs.

used by 15 state programs, allow for explicit consideration of inter-institutional differences but probably offer weaker incentives for hospitals to restrain costs.

Several finer gradations can be identified within the classification of reconciled and non-reconciled systems. Programs can be further categorized by the extent to which external standards are used to establish reimbursement. Inflation-based trend factors and peer groupings used to derive group standards or norms are most commonly used as external rate setting standards to limit cost increases and the extent to which programs, overall, depart from hospital specific costs as a basis for reimbursement. Table 1 shows reconciled and non-reconciled methods used by each state program. Within each method programs are described along a spectrum according to their use of external reimbursement standards.

Before looking at each type of reimbursement system in more detail, the reader should be reminded that, despite the widely recognized differences in the incentive structures of retrospective and prospective reimbursement systems, the cost containment outcomes achieved through each method may not be sharply distinguished. In part, this is because few of the remaining retrospective systems are purely cost-based. Most remaining retrospective systems include various limits and ceilings which may exert substantial control over rates of increase in hospital revenue and may even cause the system to look more like a prospective system. Likewise, it is necessary to remember that in reconciled programs, provider savings below any ceiling are at least partially, and in some cases entirely, retained by the state. By contrast, in prospective systems hospitals receive the entire prospectively determined rate regardless of their costs. Thus, the stronger incentive for the hospital to reduce costs under a prospective system may be more expensive to the state -- particularly in the short run -- because the state does not share in the savings.

There are three other factors which may obscure the cost results between prospective and retrospective systems. First, many states which have retained some

Table 1

Medicaid Inpatient Hospital Reimbursement Method by State

	RECONCILED			NON-RECONCILED			
State	Cost	Cost to Trend Limit	Cost to Peer and Trend Limit	Base Trended	Trended Base With Peer	Flat rate by Group	Negotiated
Alabama				X			
Arizona	------	---------	----------	----NA---	----------	--------	---------
Arkansas					X		
California*			X				X
Colorado				X			
Connecticut		X					
Delaware	X						
Washington, D.C.							X
Florida				X			
Georgia				X			
Idaho				X			
Illinois					X		
Indiana	X						
Iowa				X			
Kansas				X			
Kentucky					X		
Louisiana		X					
Maine				X			
Maryland				X			
Massachusetts				X			
Michigan			X				
Minnesota				X			
Mississippi					X		
Missouri		X					
Montana	X						
Nebraska				X			
Nevada						X	
New Hampshire	X						
New Jersey						X	
New Mexico		X					
New York					X		
North Carolina				X			
North Dakota	X						
Ohio						X	
Oklahoma				X			
Oregon				X			
Pennsylvania						X	
Rhode Island							X
South Carolina	X						
South Dakota	X						
Tennessee				X			
Texas	------	----------	----------	---NA----	----------	--------	---------
Utah						X	
Vermont							X
Virginia					X		
Washington						X	
West Virginia	X						
Wisconsin		X					
Wyoming	X						

*Two systems in effect.

form of retrospective reimbursement are states which have experienced lower than average hospital cost inflation. Second, as discussed earlier, other factors, such as the allowance for appeals or stringency of inflation or peer group standards, also contribute to the overall outcome of the reimbursement system. Finally, Medicaid is a much smaller share of the market than Medicare or than other payers combined. In some cases, hospitals are simply indifferent to Medicaid incentives because of concerns with other payers.

1. Reconciled Methods: Cost, Cost-to-Trend Limit, and Cost-to-Peer and-Trend Limit

a. Cost

Of the 15 states using only retrospective, or reconciled methods, nine continue to use Medicare's cost reimbursement. Two states have adopted alternatives to Medicare cost reimbursement as recently as October 1, 1984, and changes are being considered in five of the nine states still retaining traditional Medicare methods. South Dakota will implement a Medicaid DRG system in January 1985. Montana is considering DRG reimbursement, and Wyoming is investigating both DRGs and a formula per diem system. New Hampshire is considering alternatives for its Medicaid program but options are as yet unclear.

There may be a variety of reasons why Medicaid programs have not elected to change from cost reimbursement methods. One apparent reason is that states retaining this form of reimbursement have generally experienced below average increases in Medicaid inpatient hospital expenditures. But political and programmatic considerations apparently also mediate against program changes. In Delaware, for example, reimbursement policy has not been a priority, given limited availability of staff and the small size of its Medicaid program. South Carolina, where cost reimbursement is

also used, is the only program in the south that has not moved away from cost reimbursement.

b. Cost-to-Trend Limit

Medicaid programs in five states use formula-derived variations of cost reimbursement limited by inflation or trend factor increases. Such systems typically derive the Medicaid base reimbursement from a hospital's prior year or reporting period costs, or from a prior year limit from a set base year. Base year costs are established for per diem or per discharge units, and are trended forward for inflation (and in some cases, for intensity) with year-end reconciliation to the hospital's actual cost, subject to the trended limit. Cost-to-trend limit systems may or may not include additional incentives for volume, occupancy, Medicaid admissions or casemix.

Cost-to-trend limit methods, like other formula systems, also differ in the degree of complexity of the rate setting process. Louisiana Medicaid's program uses a relatively simple version of the cost-to-trend limit method. Per discharge rates are established for each hospital, based on prior year cost reports. The base year costs are then trended forward for hospital market basket inflation plus a 1 percent intensity allowance. End-of-year cost settlements, subject to Medicare TEFRA incentives and target limitations, are included in this system, and appeals are considered for changes in casemix and new services.

Wisconsin's program incorporates several incentive features and adjustments in the determination of Medicaid reimbursement rates. This system uses Medicare principles to establish a per discharge rate, which is trended forward from each hospital's 1981 cost report. Occupancy and volume adjustments are made by comparing 1981 discharges to current year discharges. These are then applied to base year fixed and variable costs, affecting the overall indexed rate. Individual hospital rates are also subject to TEFRA efficiency targets. A retrospective final settlement reconciles interim rates to each hospital's costs. The appeals process in Wisconsin's system

considers rate adjustments for changes in casemix, undue financial hardship, and for new and necessary services.

c. Cost-to-Peer-and-Trend Limit

Cost-to-peer-and-trend limit systems use methods similar to cost-to-trend limit systems. In addition to trending limits, this method also includes peer group standards as external controls against base cost differences.

Michigan's program is the most sophisticated of these systems, and illustrates the extent to which various incentives and methods can be combined in a retrospective formula reimbursement system. Formula methods are used in this program to limit rates of increase by the lower of a trend-related "Individual Hospital Limitation on Total Expenditures" and a "Per Diem Unit Limitation" for each of seven hospital peer groupings. Per diem costs are limited at the 75th percentile for each group. Operating costs for each hospital are adjusted for area wage levels, fiscal year, casemix and low income/special needs. Additional settlements are made for a combination of incentives/payment mechanisms, related to hospital performance. These incentives do not apply to hospitals which undergo budget review on appeal.

2. Non-reconciled Methods: Trended-Base, Base-Trended-with-Peer Group, Flat/Fixed Rates, Negotiation/Contracting

Like reconciled systems, prospective formula methods use historical costs as the base from which future rates are projected. Reimbursement is then established either from the prior year cost base, or from a fixed base year. Because there is no reconciliation to cost, the definition of base costs is particularly important to the long term cost containment potential of prospective systems. Programs which establish reimbursement each year according to the prior year's costs or which rebase hospital rates to reflect changes in capital, equipment or new services, provide weaker incentives for hospital efficiency than programs which maintain fixed base years and compound trend factor increases on a rate-to-rate basis. Trending and peer grouping standards similar to those used in cost-to-trend limit and cost-to-peer-and-trend limit systems, are

used with these methods to project reimbursement for the hospitals' rate year. Additional incentives and standards are used with some of these methods to define base period reimbursement prior to projecting hospital rates.

a. Trended-Base

Trended base systems use trend or inflation factors to establish a prospective reimbursement on a per diem or per admission/discharge basis. These are the most commonly used methods of prospective payment, and have been implemented in sixteen states. Some programs use the previous year's costs as a basis for reimbursement; other programs project reimbursement from a fixed base year. Oklahoma's Medicaid program has adopted a combined approach which projects reimbursement on the lower of costs for two consecutive years, trended forward for inflation. This highly controversial program is under major review following a series of legal battles with the hospital industry.Iowa Medicaid's prospective payment program uses a simple prospective formula method which illustrates the generic approach to a trended-base reimbursement system. In this system per diem base year operating costs are determined from the 1981 Medicare Cost Report, trended forward annually for each hospital on October 1st of each year, and applied at the start of each hospital's fiscal year. Rate adjustments are considered only for CON-approved projects through the appeals process.

Programs such as this are easy to implement and to administer. Some state programs, however, use more complex trended base methods which apply a variety of internal standards as screens to define the base unit, prior to trending. Alabama Medicaid adjusts capital costs according to minimum occupancy requirements by hospital bedsize. Tennessee's program includes adjustments for education and high Medicaid volumes, while Florida uses county reimbursement ceilings, adjusted to the Florida price level index, to establish per diem base reimbursement. The Massachusetts Medicaid program, under the state's "372" all payer system, determines reimbursement according to maximum allowable costs from the 1981 base year, trended forward and subject to

five volume adjustments established by the Massachusetts Rate Setting Commission. Casemix adjustments are allowed, but hospitals are required to provide data sufficient for this adjustment.

b. Base-Trended-with-Peer Groups

Six state programs use the base-trended-with-peer group method. This method resembles the base-trended approach, but uses external peer group standards in addition to trend factor increases, to project base year reimbursement.

New York's Medicaid program uses stringent peer group performance standards for prospective ratesetting. Implemented with New York's all payor demonstration, peer group standards based on geographic location, size, casemix, and service mix are used to screen base year costs. The peer group average plus five percent caps reimbursement for each group. The peer group standard is used in combination with a guaranteed revenue floor, established through volume adjustments, per diem controls on rates of increase, and casemix adjustments to peer group averages. New York's current program was implemented in January 1983, and reflects a refinement of a previous version of this formula system.

c. Fixed-Flat Rate Per Case Methods

Six state programs use flat rate or per case reimbursement methods based on grouping averages such as diagnostic categories to establish hospital reimbursement. These methods provide strong incentives for high-cost providers to become more efficient, but are less effective in restraining increases among low-cost providers with cost below the group norm. Flat rate systems, overall, tend toward convergence to a group mean or median. Relative to cost based systems, then, flat rate methods provide an effective mechanism for transferring reimbursement from high cost to low cost providers.

Diagnosis-Related Groups (DRGs) represent a special type of flat rate system, with 467 fixed or flat rates established on a per diagnosis basis, and are the most

prevalent fixed/flat-rate system used by Medicaid programs. Five state programs currently use DRGs as the basis for hospital reimbursement. Of these, four were adopted during 1984. Georgia attempted a "hybrid DRG" system under waiver status in the early 1980s, but abandoned it after the program encountered difficulties with systems and claims processing. South Dakota and Michigan will implement DRG systems in early 1985. States including Wyoming, Montana, and Oregon are also considering the DRG approach, and interest in this method of reimbursement is growing.

Most Medicaid DRG systems are variations of the Medicare system, with reimbursement weights adjusted for Medicaid populations. Hospitals receive an average payment per case, regardless of length of stay or service utilization. "Outliers" or cases which exceed a defined upper limit by DRG category, are reimbursed on a charge or cost percentage basis. The New Jersey program has adopted an alternative to the federal DRG system as part of its all-payer demonstration. This program combines hospital specific costs with per case reimbursement, and places lower as well as upper length of stay limits on DRG reimbursements. Cases at either extreme are reimbursed on a charge basis.

Washington state's recently implemented DRG system uses Medicare weights to determine resource consumption for each DRG and adjusts these for Medicaid casemix and discharges to establish an average cost per case. Washington's program combines hospital-specific factors with DRG flat rates, trended forward for inflation and intensity. Like Medicare's system, upper outliers only are included in this program. Outliers are reimbursed at 80 percent of cost for each case above the established threshold.

d. Negotiation/Contracting

Contracting and negotiated reimbursement systems are used in California, Washington, D.C., Rhode Island and Vermont. Relative to methods previously described, reimbursement derived through contracting and negotiation is furthest removed from

hospital costs. Reimbursement rates in such systems generally depend on strict regulation or market factors. Vermont Medicaid, for example, limits negotiated rates according to "what the state budget will bear," while programs in Washington, D.C. and Rhode Island include industry-wide maxicaps within the negotiation process. The Washington, D.C. program includes downward reconciliation if discharges are below negotiated levels. California in fact has two systems. Contracting is used in urban areas which account for about 90 percent historic Medicaid utilization. Outside of contracting areas, a cost-to-peer limit system is used. Illinois will initiate Medicaid hospital contracting in selected areas on a trial basis but at present uses a prospective formula reimbursement for the majority of hospitals in the state.

External Standards

State Medicaid programs may incorporate additional program control mechanisms which can mute or enhance these incentives and contribute to the overall effectiveness of these reimbursement methods. These include external standards incorporated within the reimbursement method, such as peer groupings and trend factors; internal control features provided through reimbursement unit incentives; and adjustments or appeals mechanisms used to reconcile final rates. The most significant of these systems features are discussed below.

a. Trend Factor

State programs, using both reconciled and non-reconciled methods, generally use an inflation index or trend factor applied to the reimbursement base to project or limit current year increases. Table 2 shows trend factors used across state programs. Hospital market baskets are the most common trending index used, especially in formula-derived reimbursement programs. Using proxies for items such as wages and salaries, dietary and medical supplies, inflationary increases can be estimated at a national and/or regional level. Most states use some variation of the HCFA-approved DRI marketbasket; a few others have developed and refined state-specific trending methods. Only four

Table 2

Medicaid Inpatient Hospital Trending Factor by State

State	CPI	CPI Medical	National Hospital Marketbasket	Regional Hospital Market-basket	1% Intensity	Maxicap	Other
Alabama				X			
Arkansas				X			
Colorado	X						
Connecticut			X				
Washington, D.C.			X			X	
Florida				X			
Georgia				X			
Idaho							X
Illinois			X				
Iowa				X			
Kansas							X
Kentucky		X					
Louisiana			X		X		
Maine				X		X	
Maryland				X	X		
Massachusetts							X
Michigan			X				
Minnesota				X	X		
Mississippi				X			
Missouri				X	X		
Nebraska	X						X
Nevada	X	X					
New Jersey							X
New Mexico				X	X		
New York							X
North Carolina				X			
Ohio	-------	----NA-----	----------	----------	----------	---------	----------
Oklahoma			X				
Oregon							X
Pennsylvania							X
Rhode Island						X	
Tennessee			X		X		
Utah	-------	----NA-----	----------	----------	----------	---------	----------
Virginia	X						
Washington				X	X		
Wisconsin			X				

states use the national CPI, alone or in combination with other indices, and two states use the CPI medical component. In addition, eleven states use maxicaps or intensity factors to allow for the increased costs of updating technology and equipment. Remaining states use a variety of combined trending factors.

b. Peer Groupings

Both retrospective and prospective systems may include peer group comparisons to limit or to project reimbursement. Peer grouping attempts to recognize reasonable differences in cost according to factors such as hospital location, bedsize, teaching status and casemix. The peer group imposes an external standard for reimbursement in one of two ways: as a screen or limit for hospital-specific base reimbursement, or as the basis for flat rates, in combination with per diem or per admission/discharge payment. Peer group standards provide effective mechanisms for controlling reimbursement for hospitals with costs in excess of the group norm, but provide relatively weak incentives for hospitals with average or below average costs to be more efficient.

The appropriate classification of hospitals into groups is of importance when peer group methods are used because reimbursement rates are established according to group norms. Medicaid rates or screens are usually based on an average or median cost for each group, or are derived through defined percentile ceilings. Grouping categories used by state Medicaid programs range from simple definitions of urban/rural status, as in the Virginia system, bedsize as used by Arkansas, or they may involve highly sophisticated classifications or grouping formulas such as New York's peer grouping system, established for all payers by the state's rate-setting authority. The New York system, for instance, uses geographic location, size, casemix, and service availability for hospital classification. Peer grouping methods by state are shown in Table 3.

Table 3

Peer Grouping Limits by State Medicaid Program

	Size	Location	Complexity	Teaching	Other
Arkansas	X				
Illinois	X		X	X	
Kentucky	X				
Michigan	X	X			
Mississippi	X				
Nevada	X	X	X		
New York	X	X	X		X
Virginia		X			
New Jersey	X	X		X	
Ohio	X	X	X	X	X
Pennsylvania	X	X	X	X	X

Internal Control Features

a. Reimbursement Unit

The reimbursement unit defines a measurable hospital product or output and provides the basis for projecting or limiting hospital payments. The choice of reimbursement unit, especially in prospective, or non-reconciled systems, can affect program incentives and disincentives for both efficiency and volumes of care. Cost reimbursement, in which payment depends on services actually provided, contains no incentives to constrain longer lengths of stay and increased resource utilization. Per diem systems encourage greater efficiency in the delivery of care, but may create incentives to increase length of stay as a means of increasing hospital revenue. Payment on a per admission/or per discharge basis provides incentives to encourage unit efficiency and also reduce length of stay. Payment systems which link diagnostic classifications with reimbursement, such as Medicaid DRG systems, provide further refinement of per admission/per discharge methods. This approach attempts to recognize the differential effects of casemix and resource intensity on hospital costs. Like other per discharge systems, a DRG approach contains strong incentives to control utilization of services within the case, but also provides strong incentives to increase the number of cases.

Reimbursement unit incentives provide clear incentives and disincentives for absolute volume increases, i.e., numbers of days or discharges, in prospective or non-reconciled systems. Volume changes in such programs are addressed directly through the reimbursement method. Cost-based systems, however, are less affected by direct incentives of the reimbursement unit, but are sensitive to differences in marginal cost efficiencies resulting from volume changes, since volume indirectly affects final reconciliations. In traditional cost based systems, for example, the unit of payment is less important as a control feature since the cost-reconciliation provides that a hospital receives only the marginal cost of additional volume. The volume incentives in hybrid-systems -- cost up to some limit -- are more complicated because they combine cost

reconciliations (which reimburse only for additional marginal costs) with ceilings (which generally vary in a manner similar to prospective systems). Thus, although hospitals with declining volumes see their ceilings decrease faster than their costs, hospitals with increasing volume may not see their reimbursement rise as quickly as their ceilings, since reimbursement is limited by their costs which only increase at a marginal rate.

Table 4 shows reimbursement units used by state Medicaid programs. Reconciled systems use cost, or cost with per diem or per discharge limits as a basis for reimbursement. Among prospective systems, the per diem is most commonly used. States which have changed their reimbursement programs more recently have selected per admission/discharge or per case reimbursement. DRG programs are included in this group. Global payment is used by three states and by the Washington, D.C Medicaid program, negotiated for 13 city hospitals and subject to a 1 percent maxicap.

b. Appeals

The appeals process provides hospitals an opportunity to receive adjustment to their rates for capital increases, new and expanded services, changes in casemix, volume, or unusual circumstances which may affect changes in a hospital's costs. Most state programs consider appeals on a case-by-case basis, through the Medicaid program directly or through the court system. Applicable capital items usually require Certificate of Need (CON) approval, but not all CON-approved projects are accepted for adjustment of hospital rates.

States appear to vary considerably with respect to the overall stringency of their appeals mechanisms, and the extent to which hospitals actively pursue rate increases through this process. Since downward rate adjustments are extremely rare, the overall cost containment incentives of state programs are particularly vulnerable to the leniency of the Medicaid appeals process and the effectiveness of Certificate-of-Need (CON) in restraining capital expansion and reimbursement increases. This is underscored by the implicit incentives of retrospective and prospective reimbursement methods.

Table 4

Medicaid Inpatient Hospital Reimbursement Unit by State

State	Cost	Cost with Per Diem Limit	Cost with Per Case Limit	Per Diem	Per Case	Global
Alabama				X		
Arizona	--NA	--- ------	--- ------	-------	-- -------	-- -----
Arkansas				X		
California*			X	X		
Colorado				X		
Connecticut			X			
Delaware	X					
Washington, D.C.						X
Florida				X		
Georgia					X	
Idaho					X	
Illinois				X		
Indiana	X					
Iowa				X		
Kansas				X		
Kentucky				X		
Louisiana			X			
Maine						X
Maryland					X	
Massachusetts						X
Michigan		X				
Minnesota*				X	X	
Mississippi				X		
Missouri		X				
Montana	X					
Nebraska				X		
Nevada*				X	X	
New Hampshire	X					
New Jersey					X	
New Mexico			X			
New York				X		
North Carolina				X		
North Dakota	X					
Ohio					X	
Oklahoma				X		
Oregon					X	
Pennsylvania					X	
Rhode Island						X
South Carolina	X					
South Dakota	X					
Tennessee				X		
Texas	--NA	--- ------	--- ------	--------	-- -------	-- -----
Utah					X	
Vermont				X		
Virginia				X		
Washington					X	
West Virginia	X					
Wisconsin			X			
Wyoming	X					

*Two systems in effect.

Cost-based systems allow hospitals to receive pass-throughs for CON-approved costs, such as capital increases and new or expanded services. Prospective reimbursement programs do not reconcile to cost, but may be sensitive to rate increases resulting from rebasing or through rate appeal.

c. Additional Incentives and Control Features

In an attempt to further refine their Medicaid reimbursement programs states may include additional incentive or control mechanisms to encourage efficiency, control Medicaid admissions or length of stay. These adjustments generally occur through appeal, reconciliation or in the establishment of rates for the following year. Virginia Medicaid's current program, for example, provides profit incentives to hospitals if their operating costs are below a defined group ceiling. Hospitals also receive adjustments for high Medicaid volumes. In Mississippi adjustments are made for new services, high Medicaid volumes and the proportionate amounts of Medicaid cost subsequent to establishment of the per diem rate. This program also imposes a nine percent penalty for over or under payment created by an overstatement or understatement of unaudited costs. Program staff maintain that this provision has significantly improved error rates in hospital reporting.

Future

With the flexibility provided by OBRA, states continue to refine and change their Medicaid inpatient reimbursement programs at a rapid pace. Within the last month at least two programs have adopted significant changes to their reimbursement programs, and 11 states are planning or considering major changes or refinements to existing programs. Meeting the challenge of the "new federalist" policies for Medicaid states are clearly demonstrating the capability to design and implement innovative approaches to hospital reimbursement on their own.

States are building on their combined experiences with design and incentive features in a deliberate attempt to integrate this knowledge for developing more

efficient and cost effective reimbursement programs. The most obvious example of this "learning curve" is the shift from reconciled to non-reconciled methods. Similar trends are noted in the shift from per diem payment, more commonly identified with programs implemented in the early 1980s, to per admission/discharge and per case reimbursement approaches with more stringent control over hospital efficiency and length of stay. The growing interest in variations of Medicare's DRG system for state Medicaid programs also marks a significant and consistent move in this direction.

Concomitant changes are occuring in the areas of utilization review and quality assurance, both as a means for controlling reimbursement increases and for assuring quality of care and access for Medicaid recipients. In an environment of changing clinical practice patterns and reimbursement priorities, definitions of "quality" and "access" are being widely challenged. While these may be extremely difficult to monitor, they nonetheless represent crucial control mechanisms to effective implementation of Medicaid reimbursement programs. These areas can be expected to attract increasing attention within the design and evaluation on Medicaid cost containment strategies.

In this paper we have provided an overview of the most significant trends in Medicaid inpatient hospital reimbursement programs across states. Attachment A provides synopses of reimbursement programs currently used in each state.

ATTACHMENT A

ALABAMA

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Prospective per diem based on prior year cost reports and trended forward for inflation every 7/1. Capital costs are adjusted according to minimum occupancy requirements: 70% occupancy for hospitals with 100 or fewer beds; 80% occupancy for hospitals with more than 100 beds.
TRENDING:	DRI Hospital Marketbasket adjusted for Alabama inflation.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	No overall standard; rate of increase in per diem is limited to trend factor increase.
RECONCILIATIONS:	Reconciliations are possible on an industry-wide basis if projected trend factor increases exceed actual inflation by more than one half of 1%. Appeals possible on a case-by-case basis.
HISTORY:	Program implemented 10-1-83, prior to which Medicare Cost Reimbursement was used.
FUTURE PLANS:	No changes planned.

ARKANSAS

REIMBURSEMENT METHOD:	Base Trended with Peer
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	A prospective per diem based on 1982 Medicare cost reports and trended forward was established for all hospitals effective 7/1/84. The per diem includes a capital cost per diem, allowances for indigent care and teaching institutions; and bundled services such as lab and X ray. Per diems are subject to peer group classification by bed size. No cost settlements are made. This method supercedes interim payment method implemented February 13, 1984, which reduced Medicaid per diems from cost report by 20% for all hospitals without year-end and cost settlements.
TRENDING:	National hospital market basket.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Peer groupings by bedsize.
RECONCILIATIONS:	None
HISTORY:	Arkansas has been experimenting with prospective payment for Medicaid since February 1984. The interim system described above provided the basis for developing the current system, which is expected to be adequate for the present and foreseeable future.
PAYMENT CYCLE:	MMIS has been in operation for several years, routine payment cycle.
FUTURE PLANS:	No changes planned.
OTHER:	Medicaid inpatients hospital reimbursement is limited to 35 diagnosis-related "PAS" days.

CALIFORNIA

REIMBURSEMENT METHOD:	(A) Negotiated; (B) Cost-to-Peer-and-Trend Limit.
REIMBURSEMENT UNIT:	(A) Per diem; (B) Cost to per-discharge limit.
SYNOPSIS:	There are two systems in California: (A) contracting, and (B) cost-to-peer-and-trend limit system. (A) Contracting applies to about half the hospitals (all urban areas) and over three quarters of the hospitalizations. A separate state agency negotiates contracts with hospitals on basis of an all-inclusive per diem. Hospitals in areas under contracting can treat Medi-Cal patients only on an emergency basis. (B) Hospitals in areas not covered by contracting (and hospitals in contracting areas for emergency cases) are reimbursed on a cost-to-peer-and-trend limit system, subject to various limits -- the most important of which is the 60th percentile of their respective peer group and a limit established by rolling forward base year (1981) costs by DRI Marketbasket index.
TRENDING:	(A) Only through contract renegotiation
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	(A) N/A; (B) Incorporated in peer group limit, and limited by trend.
RECONCILIATIONS:	(A) None; (B) End of year reconciliations to cost.
HISTORY:	Contracting phased in starting February 1983. Most of state under contracting, phased-on by July 1,1983. Peer grouping took effect in Spring 1984, but numerous appeals and adjustments made implementation ragged.
PAYMENT CYCLE:	Rather choppy; both payment cycle and settlement cycle frequently delayed toward end of fiscal year.
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Legislated disclosure of hospital costs and charges.
OTHER:	Change in definition of Medi-Cal necessity, effective September 1982. California has an extremely stringent review process -- every patient reviewed on concurrent basis; large percent of reviews done by state nurses (PSRO does some hospitals in Los Angeles).

COLORADO

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	1976 base year costs from audited cost report are trended forward by CPI plus approved add-ons June 1st of every year.
TRENDING:	CPI
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	No overall standard; rate of increase in per diem is limited by trend factor increase.
RECONCILIATIONS:	Adjustments made to current contract rate if fiscal intermediary is late in establishing new rates.
HISTORY:	Current system has been in effect since 1977.
FUTURE PLANS:	No changes planned.
OTHER:	Basically no changes since program went into effect in 1977.

CONNECTICUT

REIMBURSEMENT METHOD:	Cost-with-Per-Case Limit
REIMBURSEMENT UNIT:	Cost to per discharge limit
SYNOPSIS:	Effective for 1983, settlements switching to TEFRA system.
TRENDING:	DRI Hospital Marketbasket plus 1%.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Hospital payment may be limited by peer group.
RECONCILIATIONS:	Interim payments made on basis of CHHC approved budget allocated to Medicaid (see "State Regulatory Environment"), then reconciled. State aggregate settlement typically small, 1%.
HISTORY:	Previously (through FY ending in October 1982) reimbursed on Medicare cost basis (less nursing differential).
PAYMENT CYCLE:	Approximately 30 day delay in billing cycle when MMIS came on line, October 1, 1981.
FUTURE PLANS:	State adopted an all-payer system (May 1984) which will become operational October 1985--except for Medicare and Medicaid which will not be directly included until 1986.
REGULATORY ENVIRONMENT:	Connecticut Health & Hospital Commission has (since mid-1970s) regulated hospital charges. State adopted mandatory all-payer system (May 1984).
OTHER:	PSRO formerly provided some utilization review services. In June 1984, after a period of no UR, state started retrospective audit program to disallow excess days and admissions. (Hospitals have all guidelines on a prospective basis.) 1983 settlements have not yet been made and it is not certain exactly how TEFRA approach will be implemented. May or may not include peer group screens. (See also "State Regulatory Environment".)

DELAWARE

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since, OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	No change.
PAYMENT CYCLE:	Routine payment cycle.
FUTURE PLANS:	No plans for change at this time.
REGULATORY ENVIRONMENT:	Non-legislated voluntary budget review for Blue Cross.
OTHER:	No payments are made to state institutions. Developing reimbursement alternatives has been a low priority in Delaware, given small program staff.

DISTRICT OF COLUMBIA

REIMBURSEMENT METHOD:	Negotiated
REIMBURSEMENT UNIT:	Global
SYNOPSIS:	Contracts are negotiated with 13 hospitals in city. Rate negotiations are based on prior year cost reports and numbers of discharges, trended forward annually and subject to an industrywide maxicap of 1% per year. Capital costs are passed through; allowable operating costs are restricted to a percentage increase determined using DRI. If discharges are less than that negotiated, an end-of-the-year reconciliation of hospitals is required. Medicaid will not pay above the established rate. Third party recovery also set against PIP.
TRENDING:	DRI marketbasket inflation plus 1% maxicap, negotiated.
VOLUME ADJUSTMENTS:	Adjustments are made if the number of discharges drop below negotiated levels; rates are not adjusted for increases in numbers of discharges.
STANDARDS:	None.
RECONCILIATIONS:	Appeal through courts. If discharges are less than negotiated, end of year reconciliation is required.
HISTORY:	Started FY'83, prior to which Medicare cost reimbursement was used.
PAYMENT CYCLE:	Routine payment cycle.
FUTURE PLANS:	No changes planned.
OTHER:	The current system is an attempt to control cost and avoid service cutbacks. PSRO review of medical necessity.

FLORIDA

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Prospective per diem is calculated for each hospital based on prior year fixed and variable costs from audited cost reports, trended for inflation and limited by a county reimbursement ceiling. Reimbursement ceiling periods, or rate semesters, are effective 1-1 through 6-30, or 7-1 through 12-31 of each year. Variable costs are inflated from midpoint of hospital FY to midpoint of rate semester, using DRI Regional Hospital Index. Per diem cannot exceed the ceiling or mean calculated for all hospitals in the county, adjusted for Florida Price Level Index (Office of the Governor). Allowable costs generally follow Medicare Reimbursement Principles.
TRENDING:	DRI Regional Hospital Index.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	County reimbursement ceiling (mean county per diem) limits allowable per diems.
RECONCILIATIONS:	Some reconciliations may be necessary to account for time lags in establishing per diems because of delays in completing audits. However, actual costs are not reconciled once per diem is trended forward and rate ceiling set.
HISTORY:	Program implemented July 1, 1981.
PAYMENT CYCLE:	MMIS; routine payment cycle.
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Budget review process with cap on gross revenues per admission, and establishment of indigent care pool legislated for February 1, 1985.
OTHER:	Use of county mean as cutoff offers no incentive to hospitals below cap to control rates and may inappropriately curtail reimbursement to hospitals above cap for legitimate reasons (e.g., complex caseload). Also, constant renorming of cap allows cap to move up at roughly the same speed as hospital inflation to all payers in county. U/R Committee or PRO provides utilization review.

GEORGIA

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per case
SYNOPSIS:	Hospital-specific prospective per case rate is based on 1980 Cost Report (trended forward biannually), and number of Medicaid admissions, regardless of LOS. (Range $600-10,500.) Utilization limit or cap is set for each calendar year, based on the number of admissions in the prior state FY (7/1 to 6/30) service period (claims must be submitted by November for inclusion in service period). Reimbursement limits are set for each hospital at 100% of the number of admissions in the prior year. Admissions 100% $\geq$ 103% are reimbursed at 50% of reimbursement rate, admissions > 103% are reimbursed at 25% of rate.
TRENDING:	DRI Regional Hospital Index (4th Quarter).
VOLUME ADJUSTMENTS:	Reimbursement limits for volume increases (above).
STANDARDS:	No overall standard; limits are applied on a hospital-specific basis.
RECONCILIATIONS:	Outlier claim adjustment, based on cost to charge ratio for highest cost admission(s) category, may be allowed for one case per hospital on an individual % basis. Appeal of rate is allowed during the 60-day period prior to January 1st rate, and may be made by Medicaid according to departmental parameters (e.g., changes in services, errors in computation, etc.) Adjustments of audits for under/over payment are also made.
HISTORY:	Program implemented 1-1-83. Georgia tried a hybrid Medicaid DRG system under waiver during 1981 and 1982, but encountered major problems with systems, coding, etc., and changed to the current system in 1983. Prior to this, Medicare cost reimbursement used.
FUTURE PLANS:	No changes planned.

IDAHO

REIMBURSEMENT METHOD: Base Trended

REIMBURSEMENT UNIT: Per case

SYNOPSIS: Flat rate per admission is determined using 1980 Medicare cost report, trended forward for each hospital. Hospital reimbursed at lower of actual charge or maximum allowable per admission. Inflation/trend factor is weighted and applied by cost category (see Trending) to each facility.

TRENDING: Four (4) indexes are weighted and applied to each hospital:

Salaries:	National DRI
Dietary:	DRI
Malpractice:	CPI-Services
Other:	CPI

VOLUME ADJUSTMENTS: N/A

STANDARDS: No overall standard. Rate of increase per admission is limited to trend factor increase.

RECONCILIATIONS: Appeals possible on individual basis.

FUTURE PLANS: No changes planned.

ILLINOIS

REIMBURSEMENT METHOD:	Trended Base with Peer
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Hospital 1982 fiscal year cost report is trended forward to 1985. This rate is averaged with 1984 rate (which was rolled forward from 1981 costs) to develop rate. Therefore, the program is a combination of cost-to-cost and rate-to-rate systems. Trended rate subjected to group and volume limits.
TRENDING:	National Hospital Marketbasket--used by HCFA.
VOLUME ADJUSTMENTS:	Each hospital has volume target and there is state volume target. If state volume target is exceeded, hospitals receive only sixty-five percent of per diem above their target.
STANDARDS:	Hospitals are grouped (6 groups) and receive the lower of their own trended rates or the 65th percentile.
RECONCILIATIONS:	Only if required for volume adjustment.
HISTORY:	Current system went into effect for state FY 1985. This was the 4th year of change in an uneven evolution from cost-based reimbursement which was procedure in FY 1981. FY 1982 used retrospective system with trend limit on growth. FY 1983 moved to largely prospective system with some reconciliation. FY 1984 same as FY 1983 led to litigation which forced mid-year changes and led to current system.
PAYMENT CYCLE:	Cycle quite ragged. As high as 55-60 days in spring 1979, and at end of calendar yearrs 1981 and 1982. Now running about 20 days and has been constant.
FUTURE PLANS:	Spring 1984 legislation authorized Medicaid hospital contracting. Current plans are to begin contracting with some hospitals as early as January 1985.
REGULATORY ENVIRONMENT:	Attempted all-payer system 1979-1982, but it failed to gain sufficient political support to be implemented.

INDIANA

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since, OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	Program has not changed since 1972.
FUTURE PLANS:	Committee has taken hospital reimbursement under consideration as a future planning issue.
REGULATORY ENVIRONMENT:	Non-legislated voluntary budget review for Blue Cross, private pay and private insurance.

IOWA

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Historical per diem trended forward annually (10-1) from 1981 base year cost report and applied at start of hospital fiscal year. Medicare nursing salary cost differential is excluded from base rate.
TRENDING:	DRI-based Iowa hospital market basket.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	No overall standard; rate of increase in per diem is limited to trend factor increase.
RECONCILIATIONS:	Rate adjustment only for approved CON appeals possible on individual basis. (No providers have yet done so.)
FUTURE PLANS:	No changes planned.
OTHER:	The program has been criticized at the state level for lacking casemix adjustment, and for lack of sensitivity to changes in intensity of services at specific hospitals.

KANSAS

REIMBURSEMENT METHOD: Base Trended

REIMBURSEMENT UNIT: Per Diem

SYNOPSIS: Historical Per Diem based on 1981 Medicare cost report is established for each hospital as follows: Medicare costs are weighted and used to derive mean cost for all hospitals; hospitals are then grouped in relation to their position above or below the mean. For hospitals with costs above the mean, 2 rates apply: hospitals are reimbursed at 1981 costs plus industry inflation (negotiated annually) up to a specified number of Medicaid days, then drop to a lower rate, (i.e., the average cost for hospitals below the mean). Teaching or education costs (if any) at high cost hospitals (from 1981 base year) added as a variation of pass-thru and are subject to inflationary adjustment. Hospitals with costs below the mean receive a hospital specific per diem rate, with no limit on Medicaid days.

TRENDING: Inflationary increases are negotiated by the hospital industry and the state Medicaid program on an annual basis. Allowable increase are effective July 1 of each year. For a two-year period prior to program startup, hospitals were allowed 7% annual increases. Effective July 1, 1984, hospitals will receive 10½% inflation as a retroactive adjustment for actual inflation during these years.

VOLUME ADJUSTMENTS: Volume adjustment applies only as a limitation on rate of reimbursement for the number of Medicaid days for hospitals above the industry mean. Day limit is set by Medicaid, based on prior year utilization from cost report (1983 limit was 78% of 1981 Medicaid days; 1984 limit was 86% of 1982 days).

STANDARDS: No overall standard; rate of increase in per diem is limited to trend factor increase.

RECONCILIATIONS: Any hospital with costs 10% or greater than the per diem rate can appeal. Appeals process is active, based on reasonableness; costs are not fully recoverable on appeal.

HISTORY: Program implemented July 1, 1983.

PAYMENT CYCLE: MMIS; routine payment cycle.

FUTURE PLANS: No changes planned, but current difficulties with hospital association may result in restructuring or alteration of program.

KANSAS (CONT'D)

OTHER:	No day limits except for delivery (2 days) and psychiatric stays (14 days). Program incentives may curb utilization for large hospitals below day limit, but do not restrict low cost hospital increases in LOS. Utilization for low-cost hospitals continues to remain high. Current deadlock in negotiations with hospital association, and considerable activity on appeal. Declining Medicaid inpatient expenditures noted; some increase in OPD. Some programmatic changes limiting Medicaid days for some services (e.g., delivery and psychiatric stays) have occurred since OBRA, and have angered providers. Some interest in casemix adjustment provision.

KENTUCKY

REIMBURSEMENT METHOD:	Base Trended with Peer
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Prospective per diem rate based on latest cost report, reconciled to 1/1 and trended forward. Maximum ceilings are established based on 105% of median costs by 5 bed size categories. Medicaid fixed costs are adjusted according to 60% minimum occupancy for 100 beds or less; 75% minimum occupancy for 101 or more beds. Two adjustments are made to the prospective rate: (1) trend projections are reconciled with actual inflation rates; and (2) base year costs are adjusted to account for differences between audited and unaudited costs for the latest 6 months of the prior calendar year and January-June current year. No educational cost allowance (see comment). Legal fees for unsuccessful legal action against state or federal government and trips outside Kentucky for seminars and conferences are excluded.
TRENDING:	CPI Medical Component
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Peer group medians based on hospital bed size and minimum occupancy; trend factor increases (see synopsis).
RECONCILIATIONS:	Interim settlements and adjustments of unaudited to audited costs.
HISTORY:	Program implemented 3/1/81, prior to which Medicare Cost Reimbursement was used.
PAYMENT CYCLE:	MMIS certified 1983; 12/1/83 billing activity contracted out to private concern. Medicaid has experienced some payment difficulties as a result.
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Non-legislated voluntary budget review for Blue Cross, private pay, private insurance.
OTHER:	Inpatient hospitalization limited to 14 days per stay, with no recurrent admission within 30 days. Educational costs have been disallowed as a cost saving measure, since one teaching hospital is privately owned and the other, state operated, is financially secure.

LOUISIANA

REIMBURSEMENT METHOD:	Cost-to-Trend Limit
REIMBURSEMENT UNIT:	Cost with per case limit
SYNOPSIS:	Per discharge rate based on Medicare TEFRA cost is established for each hospital based on prior year Cost Report. Individual target rates are set for each hospital, which is subject to a payment incentive or penalty for performance relative to this target. If a hospital exceeds its target, it will receive only 25% of the excess; if the hospital's costs are below the target, it receives 50% of the difference to the target amount. Target is based on the ratio of inpatient operating costs to discharges, and trended forward. Cost settlements are included at the end of the year.
TRENDING:	National Hospital Marketbasket plus a 1% allowance for intensity.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	No overall standard; rates of increase are limited by individual hospital targets.
RECONCILIATIONS:	Appeals for rate adjustment are considered on the basis of casemix changes and new services. End-of-year cost settlement is included.
FUTURE PLANS:	No changes planned.

MAINE

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Global
SYNOPSIS:	Medicaid rates are determined by the state's Health Care Finance Commission, based on hospital FY costs prior to July 1983, through transition to first payment year. Base year costs trended forward, and subject to a gross revenue limit. Medicaid receives a 18.74% discount.
TRENDING:	DRI and region-specific hospital market basket.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Gross revenue limit.
RECONCILIATIONS:	Commission allows adjustment to rates for changes in volume, casemix.
HISTORY:	Program implanted October 1, 1984, prior to which Medicare Cost Reimbursement was used.
PAYMENT CYCLE:	MMIS; routine payment cycle.
FUTURE PLANS:	No major changes planned.
REGULATORY ENVIRONMENT:	Hospital revenues are currently subject to a gross revenue limit, established by the Health Care Finance Commission.
OTHER:	Medicaid rates under this system are less than anticipated under TEFRA.

MARYLAND

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per case (see synopsis)
SYNOPSIS:	Medicaid is part of the all-payer system in Maryland. As such, it pays 94% of approved hospital charges. Hospital charges are approved by the Hospital Rate-Setting Commission in one of two ways. Most of the hospitals (40 of the state's 55 including all large hospitals) are on the Guaranteed Inpatient Revenue (GIR) system. A total hospital revenue cap is determined by rolling forward the base year for inflation and making adjustments for casemix and volume changes. (Volume is measured on a per discharge basis.) This total revenue cap is then translated into approved charges. The Rate-Setting Commission approves charges directly for the other 15 hospitals on a roll forward of costs.
TRENDING:	Marketbasket plus 1% intensity factor (some factors national, some state).
VOLUME ADJUSTMENTS:	Variable between 50% and 80% outside corridor (1%) on downside; between 50% and 100% on upside. Percentage rises as size of volume change increases.
STANDARDS:	Only when hospital seeks a full rate hearing -- it is then compared to peer group.
RECONCILIATIONS:	No Medicaid reconciliation. Rate-Setting Commission annually does compliance reconciliation; but results are factored into following year's prospective rates.
HISTORY:	Program has been operating under Rate-Setting Commission since 1977.
PAYMENT CYCLE:	No major changes. Gradual, but slight, decrease in payment cycle over time.
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Legislated mandatory budget/rate review and approval for all lpayers.
OTHER:	20-day length of stay limitation on most diagnoses. (Tertiary diagnoses, e.g., burn, trauma, neonatal, excepted.) PSRO provides nondelegated utilization review services and pre-admission screening on all elective admissions. 6% Medicaid discount approved by Rate-Setting Commission for prompt payment and other factors.

MASSACHUSETTS

REIMBURSEMENT METHOD: Base Trended

REIMBURSEMENT UNIT: Global

SYNOPSIS: A Medicaid prospective all-inclusive per diem for inpatient hospital days established October 1981 based on hospital cost. Maximum allowable cost is subject to downward volume incentives, using 1981 base. Five types of volume adjustments are possible, based on established corridors for full 1981 payment. Adjustments are possible based on casemix changes since 1981 base--however, no such adjustments have been made to date. (Although 1981 is base year, ICD9 codes are unavailable for that year, and recreation of data base is not possible.) The "Chapter 372" all payer system was implemented by the Mass. Rate-setting Commission in 2 phases. During Phase I (10/1/81 to 9/30/82) Medicaid payments were on an interim per diem basis with end-of-year settlements. Municipal hospitals started on system with June FY. Significant savings (approx. $30 million) were reported, although data is unclear and settlements were not included in this estimate. Phase II began 10/1/82, as interim per diem was changed to percentage of charges. However, to compensate for lower reimbursements for inpatient care, hospitals requested and received 100% OPD charges. Phase I per diems reportedly used "flawed data," averaging in acute and administrative days for AFDC as well as other recipients in a "combined" per diem. Phase II split AFDC from other recipients, establishing a split Medicaid payment rate.

TRENDING: Included in rate setting formula.

VOLUME ADJUSTMENTS: Massachusetts Rate-Setting Commission uses 5 volume adjustments, with full payment (1981 base) within established corridors. Casemix adjustment is possible, with burden of proof on hospital. Poor data and inability to recreate 1981 data base has precluded such adjustment to date.

STANDARDS: None

RECONCILIATIONS: End-of-year settlements were made to interim per diem rate. Legal problems continue, given unusually large savings to Medicaid program, as hospitals feel government payments are insufficient, especially for administrative days.

HISTORY: (See synopsis)

MASSACHUSETTS (CONT'D)

PAYMENT CYCLE:	Startup of MMIS in late 1983,1984 threw off billing cycle; some hospitals did not receive payment for 4 months. June payments may be irregular or late, depending on state budget appropriation. Phase I data is very unclear; data on settlements is not in and is not distributed across recipient categories. AFDC reports are especially misleading during interim per diem payment periods, due to combining or rolling of all inpatient services for all recipient categories.
FUTURE PLANS:	The new Blue Cross Agreement (HA-30) effective retroactively October 1, 1984, includes several reimbursement changes. Medicare must approve these changes or may elect to retain current reimbursement. (Medicare waiver expires October 1, 1985.) Under HA30 Blue Cross basis of payment will be subject to a two percent productivity reduction. Productivity reduction factor will apply for all payers to reduce new program adjustment. Gross patient service revenues will be calculated using new methods tied to Blue Cross, plus a uniform statewide differential. Hospitals may select between two options for volume adjustments; including case-mix adjusted discharges.
REGULATORY ENVIRONMENT:	Mandatory all payer system; prospective budget determination on increase.
OTHER:	Perceptions of hospitals very important to implementation of 372--hospitals perceived significant changes with revenue reductions, including staff payoffs, "unbundling" of services (e.g., physician salaries) to maximize the maximum allowable cost. Considerable corporate reorganization split out many profit making entities/holding companies (e.g., real estate, laundry).

MICHIGAN

REIMBURSEMENT METHOD: Cost-to-Peer-and-Trend Limit

REIMBURSEMENT UNIT: Cost with per diem limit

SYNOPSIS:

Rates of increase are limited by the Individual Hospital Limitation on Total Expenditures and by the Per Diem Unit Limitation on operating costs. Interim payments are established using a fixed three year average (FY 79, 80, 81) as the base period, trended forward annually for hospital marketbasket inflation after the first year. At year end, adjustments are made for volume, including settlements for admissions and patient days above or below 5 percent of previous year totals.

The Per Diem Unit Limitation is established by grouping hospitals by bedsize into four urban and three rural classes and is based on the most recent Cost Report. Capital and related costs, including costs for approved educational programs, are passed through. Operating costs for each hospital are adjusted and standardized for area wage levels; fiscal year; casemix (using the Ann Arbor CM diagnosis groups), and low income/special needs. Per diem costs are then calculated and rank ordered within groups. Hospitals with costs at the 75th percentile define the per diem unit limitation for the group. Casemix adjustments from this formula are also updated for the prospective year. The Per Diem Unit Limitation and the Individual Hospital Limitation on Total Expenditures are folded into other payment mechanisms, with hospitals paid the lower amount.

In addition, hospitals receive settlements for a combination of incentives/payment mechanisms based on performance relative to the above limitations. Hospitals which undergo the budget review appeal process can get no incentive.

Hospitals with actual costs less than that issued, can receive 50% of the Medicaid program share of the incentive savings, limited to not more than 5% of program costs. If hospital costs are below both the individual Hospital Limitation and the Per Diem Unit Limitation, they receive the lesser amount in incentive payment.

Incentive payments are limited to Phase A hospitals, which tend to be high in Medicaid volume and entered the program first. Phase B hospitals (generally low Medicaid volume hospitals), are subject to rate of growth limitations and receive settlement without incentives on allowable costs.

MICHIGAN (CONT'D)

TRENDING:	Unspecified (see synopsis).
VOLUME ADJUSTMENTS:	See synopsis
STANDARDS:	See synopsis
RECONCILIATIONS:	A variety of reconciliations, incentives and settlements are possible (see synopsis).
PAYMENT CYCLE:	Routine payment cycle.
FUTURE PLANS:	A DRG system will be implemented February 1, 1985, using Medicaid-specific weights.
REGULATORY ENVIRONMENT:	Non-legislated voluntary budget review for Blue Cross.

MINNESOTA

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per case or per diem
SYNOPSIS:	Hospitals receive a prospective flat rate for all services based on 1981 cost settlement report. Operating costs are indexed for inflation and intensity/technology. Hospitals with 100 Medicaid admissions or more receive payment on a per admission basis, providing financial incentives for earlier discharge. Hospitals with fewer Medicaid admissions may choose payment on a per admission or per diem basis.
TRENDING:	DRI regional marketbasket subject to maximum limitation set by the Legislature, plus 1% intensity/technology adjustment.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	No overall standard; limitations are applied to individual hospitals.
RECONCILIATIONS:	Casemix and services are assumed to be unchanged from 1981 base, but can be appealed. Adjustments may also be made for catastrophic cases.
REGULATORY ENVIRONMENT:	Legislated voluntary budget/rate review for Blue Cross and charge-based payers.
OTHER:	Program provides incentives to reduce LOS for hospitals reimbursed on a per admission basis and hospitals appear to be responding accordingly. Providers and social workers have expressed concern over early dismissals. Appeals process has been active and a problem for program.

MISSISSIPPI

REIMBURSEMENT METHOD:	Base Trended with Peer
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	A prospective per diem is established annually every 7/1, based on the most recent cost report. Allowable costs do not include nursing salary differential. Capital costs resulting from changes in ownership are non-reimbursable for the first four years and are prorated until after a 13 year period, at which time these costs are separated into capital, education and operating components. The capital component is limited by the ratio of total capital to the largest of Medicaid patient days or specified occupancy levels, based on hospital bed size. Operating costs are inflated to a common year end (12/31). Per diems are then arrayed by hospital and are capped at the 80th percentile. A trend factor is applied to operating costs only, from the midpoint of the report period to the midpoint of the reimbursement period (7/1-6/30). Capital, education, and operating components are added together to derive the all-inclusive rate. A 9% penalty is imposed for over or under payment, based on audited rates.
TRENDING:	DRI Hospital Marketbasket with regional adjustment.
VOLUME ADJUSTMENTS:	Capital costs are limited by the ratio of total capital to the largest of patient days or specified occupancy levels.
STANDARDS:	Peer groupings by hospital bed size (5 categories).
RECONCILIATIONS:	Appeal possible on a case-by-case basis. Adjustments may be made for new services, high Medicaid volumes,or the proportionate amounts of Medicaid cost subsequent to establishment of per diem rate.
HISTORY:	Program implemented July 1, 1981, prior to which Medicare Cost Reimbursement was used.
FUTURE PLANS:	Medicaid program is looking at DRG reimbursement, but no changes are planned at this time.
OTHER:	The 9% penalty for over or under payment of rates has significantly improved error rates in hospital reporting.

MISSOURI

REIMBURSEMENT METHOD:	Cost-to-Trend Limit
REIMBURSEMENT UNIT:	Cost with per diem limit
SYNOPSIS:	All inclusive prospective per diem is established using Cost Reports and based on lowest of three factors: Medicare rate; prior year audited costs trended forward for Marketbasket inflation; Title XIX costs determined by Cost Report three years prior and trended each year to current rate year. Rates are determined annually, and implemented in January or July, depending on hospital FY. Medicaid program recoups the difference if Title XIX payments exceed costs through end of year reconciliation.
TRENDING:	Missouri-specific DRI Marketbasket plus 1% intensity factor. Marketbasket is regional where possible; CPI and other indicators are also used for comparison.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	None
RECONCILIATIONS:	End of year reconciliation up to limit.
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Non-legislated voluntary budget review for Blue Cross of Kansas City; private pay; private insurance.

MONTANA

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since, OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	No change.
PAYMENT CYCLE:	Routine payment cycle.
FUTURE PLANS:	Montana is considering DRGs for Medicaid, including establishing Medicaid-specific DRG rates.

NEBRASKA

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Prospective per diem flat rate based on audited prior year cost reports was implemented 7-1-82. Implementation staggered by hospital fiscal year. Nursing salary differential is excluded.
TRENDING:	CPI of 5.9% was allowed for '83, '84 rates.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	No overall standard. Rate of increase in per diem is limited to trend factor increase.
RECONCILIATIONS:	Rates appealable on a case-by-case basis within 90 days.
HISTORY:	Program implemented 7-1-82, prior to which Medicare Cost Reimbursement was used.
PAYMENT CYCLE:	Routine payment cycle.
FUTURE PLANS:	No changes planned.

NEVADA

REIMBURSEMENT METHOD:	Flat Rate by Group
REIMBURSEMENT UNIT:	Per Diem; Per Case
SYNOPSIS:	A fixed rate based on bed size and service provision is established for large urban, intermediate, and small hospitals (9/1/83) using prior calendar year costs and trended forward. Four per admission rates are developed for each group: general acute; maternity; newborn; and neonatal. Base period is 4/1/82 - 6/30/82; per admission rates are based on the lowest cost (most efficient) hospital in each group. Alcohol and mental illness services are reimbursed on a cost basis.
TRENDING:	Greater of National CPI or 1/2 Medical component.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Peer groupings differentiate large urban intermediate and small facilities on the basis of bed size and services, and provide the basis for fixed rates. Rates are also subject to allowable trend factor increases.
RECONCILIATIONS:	Appeals possible for hospitals serving disproportionate members of indigent patients on a case-by-case basis.
HISTORY:	Program was implemented 9/1/83, prior to which Medicare Cost Reimbursement was used.
PAYMENT CYCLE:	Routine payment cycle.
FUTURE PLANS:	No changes indicated at this time.
REGULATORY ENVIRONMENT:	No
OTHER:	Pre-admission screening is required. ADS beyond 3 per admission require per case authority. PRO conducts pre-admission and concurrent review. Medicaid staff notes that the program has been quite effective, reducing LOS.

NEW HAMPSHIRE

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since, OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	No change.
PAYMENT CYCLE:	MMIS; payment cycle routine.
FUTURE PLANS:	The program is currently exploring alternatives to cost reimbursement, but has no definite plans at present.
OTHER:	PSRO provides utilization review services. As a result of TEFRA changes, the program is seeking approval for ceiling limits on routine costs and exclusion of TEFRA incentives which are costly for the New Hampshire program.

NEW JERSEY

REIMBURSEMENT METHOD:	Flat Rate by Group (DRG)
REIMBURSEMENT UNIT:	Per case
SYNOPSIS:	Uses DRG system (468 diagnostic categories) where DRG payment is based on an average of hospital's historic costs and historic peer group costs. DRG rate then multiplied by a hospital-specific "mark-up" factor which includes administrative costs and uncompensated care.
TRENDING:	Internally developed index based on state input requirements.
VOLUME ADJUSTMENTS:	A variable cost adjustment is used for the hospital-specific portion of costs and part of indirect costs; however, the bulk of volume adjustment happens through per admission payment approach.
STANDARDS:	Peer groupings, trend factor increases and DRG rates limit increases as above.
RECONCILIATIONS:	Necessary to make adjustments for inflation and volume misprojections as well as differences in payer mix.
HISTORY:	Some history of regulation. Medicaid previously on SHARE system which was a budget review process. Current DRG system was phased in over three years starting in 1980.
PAYMENT CYCLE:	Routine payment cycle.
FUTURE PLANS:	Current waiver status uncertain; will be determined in early 1985.
REGULATORY ENVIRONMENT:	DRG system is a mandatory all payer system including budget/rate per case review and approval. State has long regulatory history, mostly through various forms of budget review. SHARE program - affecting Blue Cross and Medicaid - from 1976 on.
OTHER:	PRO provides utilization review services along with standards similar to rest of state. DRG system was rebased on 1982 data, which seems to have caused unplanned rate increase -- the magnitude of which is uncertain.

NEW MEXICO

REIMBURSEMENT METHOD:	Cost-to-Trend Limit
REIMBURSEMENT UNIT:	Cost with per case limit
SYNOPSIS:	TEFRA system without peer grouping. That is, past year cost per discharge trended forward. Hospital paid target rate or actual costs, whichever is lower.
TRENDING:	DRI Marketbasket with regional adjustments, plus one percent intensity allowance. May adopt lower rate on interim basis effective January 1, 1985.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	Effective from 1984 onward. Previously used Medicare cost reimbursement.
FUTURE PLANS:	Considering options, both for Medicaid and, possibly for all payers.
REGULATORY ENVIRONMENT:	CON regulation allowed to "sunset" in 1983.
OTHER:	Prior approval required for some procedures; utilization review is mostly delegated.

NEW YORK

REIMBURSEMENT METHOD:	Base Trended with Peer
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	A complex formula system is used in New York's all payer waiver demonstration to establish a prospective per diem, subject to peer group performance standards controls on rates of increase and a guaranteed revenue floor (through volume adjustments). The per diem is calculated based on each hospital's 1981 routine and ancillary costs, trended forward for inflation and adjusted for "phase-in" components of the new system to derive revenue levels in 1984 and 1985. Peer group comparisons by geographic location, size, casemix, and service mix are used to screen base year costs; the peer average plus five percent serves as the reimbursement ceiling for the group. A combined routine cost/length of stay standard based upon a case-mix adjusted group average routine cost per expected day, allows a 7.5% corridor for hospitals with costs above their group average.
TRENDING:	A peer group-specific trend factor is determined yearly by an independent panel of economists.
VOLUME ADJUSTMENTS:	The three year Guaranteed Revenue Cap provides incentives to encourage elimination of unnecessary patient days, admissions and their corresponding costs, since the cap provides a guaranteed revenue floor (through volume adjustments) which is not dependent upon the number of days of care provided. Adjustments to the revenue cap will be provided to accommodate significant changes in volume or casemix, approved addition or deletion of services or reasonable increases.
STANDARDS:	Peer group averages and trending restrict per diem rates, applied through each hospital's guaranteed revenue cap.
RECONCILIATIONS:	The prospective revenue cap for each hospital will be adjusted only for significant changes in volume, case-mix, program or service changes or labor costs.

NEW YORK (CONT'D)

HISTORY:	Program implemented January 1983, prior to which NY Medicaid hospital reimbursement was stringently regulated under a previous version of the present formula system.
PAYMENT CYCLE:	MMIS phased in from 1977 to 1982, shifting payment from local to central authority.
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Mandatory all-payer system prospectively caps hospital inpatient revenues; administered through Department of Health.
OTHER:	The New York demonstration possesses very stringent cost containment incentives as well as incentives to control admissions and LOS. Medicaid officials claim that their program is a superior one, achieving desired effects without compromising quality access or hospital financial viability. Program eligibility is increased yearly, and is likely to be reflected in Medicaid reimbursement. Efforts to increase Medicaid HMO involvement may also affect inpatient hospital reimbursement.

NORTH CAROLINA

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Prospective per diem is based on 1981 base year operating costs trended forward annually for each hospital (11-1) at start of hospital fiscal year. Medicare cost report is used to determine rates for fixed capital and operating costs. Adjustments to the rate are considered for CON approved projects on a case-by-case basis.
TRENDING:	DRI-based North Carolina hospital index.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	No overall standard; rates of increase in per diem are limited by trend factor.
RECONCILIATIONS:	Appeal possible on a case-by-case basis. Capital rate adjustments generally require CON approval. Adjustment may be made for changes in casemix, (i.e., changes in the relative proportion of routine and special care) and for new services.
HISTORY:	Program implemented 11/1/81, prior to which Medicare Cost Reimbursement was used.
FUTURE PLANS:	No changes planned.
OTHER:	Casemix rate adjustment is initiated by the hospital and is likely to be adjusted upward, if at all.

NORTH DAKOTA

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since, OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	No changes.
PAYMENT CYCLE:	Routine payment cycle; MMIS implemented in 1978.
FUTURE PLANS:	No changes planned.

OHIO

REIMBURSEMENT METHOD: Flat rate by group (DRG)

REIMBURSEMENT UNIT: Per case

SYNOPSIS: A Medicaid-specific DRG system was implemented 10-1-84. Medicaid relative weights are applied to Medicare's 468 DRG categories. Four years worth of Medicaid claims data are used as the basis in developing relative weights. These are adjusted for indirect and direct medical education, wages and malpractice, and inflated to a 1983 cost. Payment rates are established on a peer group basis as follows:

- o average cost per discharge component
- o wage component for teaching hospitals
- o teaching component for teaching hospitals
- o capital component for all hospitals

The following blending applies for DRG payment: 10/1/84 tc 6/30/85 - 50% hospital specific and 50% peer group average costs; 7/1/85 to 6/30/86 - 25% hospital specific and 50% peer group average cost.

Ohio's system defines both day outliers and cost outliers. Outlier payment is based upon a percent of either the per diem payment or cost payment.

TRENDING: N/A

VOLUME ADJUSTMENTS: N/A

STANDARDS: 14 Peer groupings based on location, bedsize, medical education, and exclusivity of service.

HISTORY: Program implemented 10/1/84, prior to which Medicare cost reimbursement was used.

FUTURE PLANS: No changes planned.

REGULATORY ENVIRONMENT: Non-legislated voluntary budget review for Blue Cross; private pay; private insurance.

OKLAHOMA

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Per diem rate for each calendar year is the lower of costs reported before 6/30/81 or 6/30/82, trended forward.
TRENDING:	National DRI marketbasket.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	No overall standard; rate of increase in per diem is limited by trend factor increase.
RECONCILIATIONS:	N/A
FUTURE PLANS:	(See "Other").
OTHER:	This program is currently undergoing major evaluation/review following filling of major lawsuits questioning the fairness of rate setting methods. Continuing legal battles with the hospital industry have credited considerable uncertainty on Medicaid practices.

OREGON

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per case
SYNOPSIS:	A hospital-specific historical flat rate is established for any Medicaid admission after July 15, 1983, regardless of LOS or intensity, based on 1981 Medicare cost reports. Payment is on a per-discharge basis.
TRENDING:	Inflation factor unspecified.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Reimbursement is limited by eligibility restrictions for inpatient hospitalization, at 12 days per FY for General Assistance recipients and 18 days per FY for Title XIX recipients.
RECONCILIATIONS:	Appeals are possible for changes in hospital corporate structure; capital; and new and expanded services.
HISTORY:	Program implemented July 15, 1983, prior to which Medicare Cost Reimbursement was used.
PAYMENT CYCLE:	MMIS implementation in June 30, 1982 resulted in significant delays in billing. Prior authorization for hospital, stays required as of February 1, 1984, has resulted in slight claims processing delays.
FUTURE PLANS:	Last year, the Oregon Legislature allocated money for the study of DRGs. Starting January 1985, some hospitals may be reimbursed for DRGs on an experimental basis.
REGULATORY ENVIRONMENT:	Legislated voluntary budget/rate review for Blue Cross and charge-based payers.
OTHER:	Reimbursement for inpatient stays is limited to 12 days per FY for General Assistance recipients and 18 days per FY for other Title XIX recipients. Prior authorization for hospital stays has been required since February 1, 1984. Utilization review is performed by PRO.

PENNSYLVANIA

REIMBURSEMENT METHOD:	Flat rate by group (DRG)
REIMBURSEMENT UNIT:	Per case
SYNOPSIS:	A DRG payment system was implemented July 1, 1984. Pennsylvania's program uses Medicaid-specific DRG weights for Medicare's DRG groupings. 8 peer groupings, derived from 16 factors, such as size, location and teaching status are used to develop DRG flat rates. This system blends peer groups and hospital-specific prospective rates on a 25/75 percent basis during the first year; a 50/50 percent basis during the second year; and 100% peer grouping by the third year. The state will compare rates of increase from the cost report to the general inflationary rate for calculation of DRG rates in subsequent years.
TRENDING:	Unspecified
VOLUME ADJUSTMENTS:	N/A
HISTORY:	DRG payment system implemented 7-1-84, prior to which a retrospective cost-to-limit system with per diem payments was used.
FUTURE PLANS:	No change.
UTILIZATION:	Utilization review is performed by state Medicaid program.
REGULATORY ENVIRONMENT:	Non-legislated voluntary budget review/negotiated formula system for Blue Cross of W. Pennsylvania.

RHODE ISLAND

REIMBURSEMENT METHOD:	Negotiated
REIMBURSEMENT UNIT:	Global
SYNOPSIS:	Rates are negotiated through budget review for individual hospitals, subject to an industrywide maxicap established by the state's rate review program. Allowable costs for Medicaid are basically Medicare costs, with exceptions to permit payment in excess of aggregate charges.
TRENDING:	Inflation is included in negotiation of maxicap.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Standards are negotiated through budget review, and subject to negotiated maxicap.
HISTORY:	Current system has been in effect prior to, and since, OBRA.
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Non-legislated voluntary; prospectively negotiated Maxicap for Medicaid and Blue Cross.

SOUTH CAROLINA

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since, OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
PEER STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	No changes.
PAYMENT CYCLE:	Certified MMIS; routine payment cycle.
FUTURE PLANS:	No changes planned.
OTHER:	Inpatient hospital services are limited to 12 days per year (South Carolina is the first state in Region 4 to impose such a limit). Utilization Review provided by South Carolina Medi-Cal Association PRO. South Carolina is also the only state in Region 4 that has not adopted a prospective payment system for Medicaid. Strong legislative state with many county-owned hospitals, and strong hospital industry.

SOUTH DAKOTA

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since, OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End-of-year reconciliation to cost.
HISTORY:	No changes.
PAYMENT CYCLE:	MMIS since 1982; routine payment cycle.
FUTURE PLANS:	Medicaid will start DRG payment January 1, 1985, using Medicaid-specific rates.

TENNESSEE

REIMBURSEMENT METHOD:	Base Trended
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Prospective per diem, based on audited Cost Report for last reporting period trended forward annually. Capital costs are passed through each year; operating costs only are indexed. Minimum occupancy levels are 70% for 100 needs and greater, and 60% for 99 beds or less. Rate adjustments for capital improvements and new services are considered on a case-by-case basis. Adjustments are made for education and high Medicaid volumes (2% above current allowable inflation). Revalued assets (sale) are not recognized in the rate.
TRENDING:	National DRI Hospital marketbasket plus 1% intensity/ technology factor.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	None
?	
RECONCILIATIONS:	End of year settlement of unaudited to audited rates.
HISTORY:	Program implemented 10/1/83, prior to which Medicare Reimbursement was used.
FUTURE PLANS:	No changes planned.
OTHER:	Medicaid is primarily a policy-oriented agency in Tennessee. Desk review and rate-setting are done by the Office of the Attorney General.

TEXAS

REIMBURSEMENT METHOD:	N/A
REIMBURSEMENT UNIT:	N/A
SYNOPSIS:	Contracts are negotiated with health insurance contractor for coverage of hospital inpatient/outpatient and physician services, lab and X-ray on a risk sharing basis. For the 1st year of the program, premiums are established according to contractor bids, subject to negotiation in subsequent years. Medicare cost reimbursement under TEFRA is used to target cost per discharge; premiums are negotiated using actuarial time series and trend analyses for two risk groups: AFDC and Aged/Blind/Disabled. Risk is shared on an 85%/15% basis above or below a 91-109% corridor of premium costs, at which point the state or contractor must refund costs to the program.
TRENDING:	None, since premium is negotiated.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	Quota share reconciliation.
FUTURE PLANS:	Texas is considering development of a Texas DRG" program with Medicaid-specific weightrs and state utilization and cost bases.
OTHER:	The availability of data for actuarial analysis allows the Texas program this option. One contractor (EDS) is used for the entire state, averaging out great differences in cost of living for urban/rural areas. The state contract is put for bid every 2-3 years.

UTAH

REIMBURSEMENT METHOD:	Flat Rate by Group
REIMBURSEMENT UNIT:	Per case.
SYNOPSIS:	DRG rates for Medicaid have been established at 20% below Medicare rates. Hospitals are reimbursed at 60% minimum, and 110% maximum of billed charges. The same rates apply for urban and rural hospitals; psychiatric units of general hospitals and neonatal units are included (two hospitals are exceptions).
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
FUTURE PLANS:	No changes planned.
OTHER:	The Medicaid program reports that despite rates and LOS below the national average (prior to DRGs), the program appears to have affected decreases in inpatient expenditures, shorter LOS, slowing in increases and overall decrease in utilization. Utah Medicaid is currently examining DRG weights.

VERMONT

REIMBURSEMENT METHOD:	Negotiated
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Per Diem is negotiated between Medicaid and each hospital, based on prior year billed claims (used to calculate the ratio of Medicaid patient days to charges), and the available budget of the Medicaid program. No direct inflation indexing is used; rather, this is determined through negotiation and is subject to the state's overall appropriation to the Medicaid program. Once contracts have been negotiated, no changes are made.
TRENDING:	None (see synopsis).
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Per Diem rates are subject, ultimately, to the availability of state-appropriated funds.
RECONCILIATIONS:	None, since Per Diem is negotiated.
FUTURE PLANS:	No changes planned.
OTHER:	Negotiations with providers have been successful and the program has kept within budget.

VIRGINIA

REIMBURSEMENT METHOD:	Trended Base with Peer
REIMBURSEMENT UNIT:	Per Diem
SYNOPSIS:	Prospective per diem based on prior year cost reports. Operating costs are analyzed for all hospitals by urban/rural status, and a median established as the per diem base for each group. Median operating costs are indexed for inflation; depreciation, capital interest and education costs are passed through. The per diem is then adjusted for the following: if projected operating costs are less than the ceiling, hospitals are given a "profit incentive" and may recover a maximum of 25% of the projected cost and the difference between the median for their group. Adjustments to the rate are made for high Medicaid volume increases. (See volume.)
TRENDING:	National CPI, adjusted quarterly.
VOLUME ADJUSTMENTS:	Additional percentage difference above 8% Medicaid utilization is added to hospital-specific per diem (Medicaid program has established its own utilization review program, disallowing some hospital stays).
STANDARDS:	Median "ceilings" for urban and rural hospitals limit allowable per diem.
RECONCILIATIONS:	Moving base year provides reevaluation of fixed cost annually, or on the basis of interim cost reports.
HISTORY:	Program implemented July 1, 1982, prior to which several program initiatives were attempted.
PAYMENT CYCLE:	MMIS; payment cycle routine.
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Legislated voluntary budget/rate review for charge-based payers.
OTHER:	Hospital stays are limited to 21 days. No Friday, Saturday admissions are allowed. Program has its own utilization review committee to screen accounts and length of stay.

Virginia's program is described as similar to "Medicare with a cap." Although the program has been in operation only since July 1, 1982, cost savings to Medicaid appear to be significant. However, use of the median for establishing per diem ceilings is felt by some to be rather stringent, especially for higher cost hospitals. There are some indications that hospital costs are exceeding the per diem, even for facilities below the cutoff. In addition, several hospitals may be receiving unjustifiable profit incentive payments. There is also concern that use of the CPI as an index may be too low as a predictor of hospital industry inflation. The long-term effects of increasing intensity of services resulting from capital or educational pass throughs, as well as overall increases in operation, should be monitored, especially given the moving base year. Use of medians as standards for rates may also inappropriately impact hospitals on the basis of casemix complexity or year-to-year changes.

WASHINGTON

REIMBURSEMENT METHOD:	Flat rate by Group (DRG)
REIMBURSEMENT UNIT:	Per Case
SYNOPSIS:	A Medicaid DRG system was implemented 10-1-84. Medicare weights are applied to Washington Medicaid 1983 costs, inflated by the Market Basket price index. DRGs include a blending of hospital-specific costs with statewide average cost. Hospital specific costs independent of patient treatment are reviewed through the Washington State Hospital Commission's budget review process, i.e., adjustments are made for capital and teaching as approved budgeted cost to base year cost.
TRENDING:	DRI hospital market basket plus 1 percent intensity.
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	Trend factor increases and DRG rates limit increases as above.
RECONCILIATIONS:	Washington State Hospital Commission determines allowable costs and mediates exceptions.
HISTORY:	Program implemented 10-1-84 prior to which Medicaid cost reimbursement, subject to Washington State Hospital Commission Review, was used. Washington implemented a statewide demonstration from 1977-1980/1, randomly assigning hospitals to one of three payment approaches: Medicare cost reimbursement; percentage of budgeted historical cost and; billed charges with no retrospective adjustment.
PAYMENT CYCLE:	Routine MMIS
REGULATORY ENVIRONMENT:	Washington State Hospital Commission reviews hospital costs. As of 1984, enabling legislation broadened the Commission's powers, authorizing patient billing for a casemix data base and a statewide revenue limit (on an experimental basis) from one and one-half to two years.

WEST VIRGINIA

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	No change.
PAYMENT CYCLE:	MMIS was implemented in January 1982. Slight startup difficulties during year one, but the system has been relatively stable since. Prior to MMIS, billing cycles were bi-monthly. Most changes with billing/payment have been the result of fiscal problems (e.g., 1982) rather than systems. Limited availability of funds has disrupted payments to hospitals, as payments are held until such funds are appropriated. Inpatient hospitalization is currently at a 90-day turnaround.
FUTURE PLANS:	Health Care Cost Review Authority was established last year and will set rates for hospitals project 12/1/85. While the methods are as yet unspecified, it is expected that an aggregate gross revenue limitation for hospitals will be adopted.
REGULATORY ENVIRONMENT:	Health Care Cost Review Authority will set hospital rates, projected for 12/1/85.
OTHER:	Medicaid limits inpatient hospitalization to 20 days per fiscal year for each recipient.

WISCONSIN

REIMBURSEMENT METHOD:	Cost to Trend Limit
REIMBURSEMENT UNIT:	Cost with per case limit
SYNOPSIS:	Formula system based on Medicare principles is used to establish per discharge rate, trended forward from individual hospital fiscal year 1981 cost report. Occupancy and volume adjustments comparing 1981 discharges to current discharges are applied to fixed and variable costs, affecting the overall indexed rate. A retrospective final settlement reconciles interim rate at actual rate for each hospital. Actual reimbursement is lower of current year costs or charges, or indexed 1981 rate.
TRENDING:	DRI hospital market basket applied to each hospital.
VOLUME ADJUSTMENTS:	Occupancy and volume adjustments are applied to 1981 fixed and variable costs as part of the formula system, reducing allowable rates of increase and spreading fixed costs over current units.
RECONCILIATIONS:	Appeals are possible through the adjustment committee and are considered in cases of casemix changes, undue financial hardship, and for new and necessary services.
HISTORY:	(See "Other")
FUTURE PLANS:	No changes planned.
REGULATORY ENVIRONMENT:	Legislated mandatory review for Blue Cross and charge based payers.
OTHER:	Major changes since OBRA include developing efficiency targets, peer group costs, etc. There is some indication that LOS and Medicaid expenditures are dropping with the per discharge system. Current attention is being directed toward HMO effects, especially in the Madison area--many hospitals are reportedly laying off staff out of concern for lower volume, revenue.

WYOMING

REIMBURSEMENT METHOD:	Medicare Cost Reimbursement
REIMBURSEMENT UNIT:	Cost
SYNOPSIS:	Medicare Cost Reimbursement has been used prior to, and since, OBRA.
TRENDING:	N/A
VOLUME ADJUSTMENTS:	N/A
STANDARDS:	N/A
RECONCILIATIONS:	End of year reconciliation to cost.
HISTORY:	No change.
FUTURE PLANS:	Wyoming may begin a pilot plan for Medicaid DRG payments by October 1984. Medicare DRG payments have increased payments to hospitals, which favor this approach. Proliferation of swing beds and psych units has been noted by Medicaid officials. An alternative under consideration is establishing a per diem rate, with some limits on inclusion of components.